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MONTANA RELATIVE VALUE FEE SCHEDULE

for

Medical, Chiropractic and Paramedical Services

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INTRODUCTION

The 1985 Legislature enacted Senate Bill 409 affecting the maximum medical fee schedule published by the Division of Workers' Compensation and used by workers' compensation insurers providing coverage in Montana.

Senate Bill 409 provided the maximum fee schedule be adopted as a relative value fee schedule for medical, chiropractic and paramedical services, with unit values to indicate the relative relationship within each grouping of specialties. Medical fees are based on the median fees as billed to the State Compensation Insurance Fund during the year preceding the adoption of the schedule. The fee schedule is to be established annually by the Division, to be effective in January of each year.

Relative unit values, instructions, definitions and explanations for most procedures are found in this and three other publications:

Official Medical Fee Schedule for Services Rendered Under the California Workers' Compensation Laws, (OMFS), California Workers' Compensation Institute.

Relative Value Guide, (ASA), American Society of Anesthesiologists, 1985 Edition.

1985 Health Care Procedure Coding Schedule, (HCPCS), U.S. Health Care Financing Administration.

HOW TO USE THE SCHEDULE

Insurers can determine the maximum amount payable by multiplying the procedure's relative unit value by the corresponding specialty area's conversion factor and rounding to the nearest hundredth. Insurers should NOT use a conversion factor from one specialty area to determine the maximum amount payable in another specialty area. For example, do not use the surgery conversion factor to determine the maximum fee for a medical procedure. Relative unit values for procedures can be found in either the Montana Relative Value Fee Schedule (MRVS), OMFS or ASA.

A Relative Unit Value (RUV) is now established for many services in OMFS indicated as "Relativity Not Established" (RNE) and for many new services. Further descriptions of such services may be found in the Physician's Current Procedural Terminology (CPT).

Services or procedures indicated in the OMFS as "By Report" (BR) or "Service" (SV) retain their designations. Anesthesia procedures indicated as "Individual Consideration" in ASA are defined by the Division as BR.

The Montana Relative Value Fee Schedule is divided into seven (7) specialty areas.

Medicine
Anesthesia
Surgery
Radiology - Professional Component
Radiology - Total
Pathology
Dental

Each specialty area is printed on separate color paper for ease of identification. Each specialty area is listed in ascending order. Each procedure has its procedure code identification, a short description and the procedure's relative unit value.

If the procedure is not listed in the MRVS, then consult the OMFS, HCPCS, or ASA to see if it is listed there. If the procedure is listed in the OMFS, then use its RUV. If a procedure does not exist in either the Montana Relative Value Fee Schedule, OMFS, ASA, or HCPCS, it may be a newly developed procedure or is not described properly.

Procedures listed as RNE should be paid on a case-by-case basis. Any new procedure created after the effective date of this publication and before the issuance of a new schedule should be treated as RNE.

A procedure listed as BR should be justified by the medical service provider since the procedure is too variable in nature of its performance to permit assignment of a RUV. Fees for such procedures need to be justified "by report." A DETAILED CLINICAL RECORD IS NOT NECESSARY.

A procedure listed as SV is not a single procedure, but rather a combination of several procedures listed in OMFS, ASA or MRVS.

The SV procedures, although identified by a specific code number, can be described only in terms of several services included together. Therefore, a RUV is not indicated for SV procedures and the total RUV is derived from the relative unit values for each individual service performed. When a medical service provider utilizes a SV procedure, the medical service provider should describe in its billing which procedures make up the services rendered, by itemizing each individual service, listing the code number and the fee for each.

SPECIAL POINTS TO KNOW

Anesthesia procedure codes identified in OMFS are not to be used. The ASA procedure codes are to be used instead.

The following medicine procedure codes may be used only when appropriate skills and time warrant use of such procedures and must be accompanied by detailed examination and operative notes: 90015, 90020, 90026, 90060, 90070, 90080, 90085, 90220, 90230, 90270, 90610, 90620, 90625 and 90630.

For the surgery specialty group insurers must use the follow-up days in OMFS to determine acceptable levels of service after surgery, as well as the surgical ground rules.

The American Dental Association codes correspond with the HCPCS codes.

OTHER POINTS OF INTEREST

Medical service providers are urged to use the appropriate accident number on their billings. Failure to do so may result in delay in payment from the insurer. Spaces are provided on all medical service provider forms for accident numbers.

The current Division medical service provider forms are in Appendix A. Supplies of these forms can be requested by writing to the Insurance Compliance Bureau. Insurers and medical service providers should use the most current version of the Division forms. The date of the version of the form is indicated in the lower left hand corner of the form along with its proper form identification number. Insurers and medical service providers may reproduce current versions of forms.

Appendix B tells how to order OMFS, ASA and HCPCS. Please note discount prices for various quantity breaks. Each publication must be prepaid.

Questions or comments concerning the Montana Relative Value Fee Schedule should be directed to the Insurance Compliance Bureau, 5 South Last Chance Gulch, Helena, Montana 59601.

CONVERSION FACTORS

Conversion factors to be effective January 31, 1986 and applied to the 1986 Montana Relative Value Fee Schedule for Medical, Chiropractic and Paramedical Services (MRVS) are as follows:

Medicine		$5.14
Anesthesia		$37.80
Surgery		$128.00
Radiology		
	Professional	$1.64
	Total	$10.23
Pathology		$1.25
Dental		$7.00

MEDICINE SECTION

PROC	SHORT DESCRIPTION	RUV
90017	OMS NEW PATIENT EXTENDED SERVICE	13.1
90115	HOME MS NEW PATIENT INTERMEDIATE SERVICE	RNE
90117	HOME MS NEW PATIENT EXTENDED SERVICE	RNE
90150	HOME MS EST PATIENT LIMITED SERVICE	3.9
90170	HOME MS EST PATIENT EXTENDED SERVICE	RNE
90280	SUBS HOSP CARE EA DAY COMPREHENSIVE SERVICES	14.6
90292	HOSPITAL DISCHARGE DAY MANAGEMENT	8.2
90300	LTCF BRIEF HIST/EXAM INIT OF DX/TRMNT PROG	RNE
90315	LTCF INT HIST/EXAM INIT OF DX/TRMNT PROG	RNE
90350	LTCF SUBS CARE LIMITED CARE	3.9
90450	NH EST PATIENT LIMITED SERVICE	4.7
90460	NH EST PATIENT INTERMEDIATE SERVICE	RNE
90505	EM RM NEW PATIENT BRIEF SERVICE	5.9
90517	EM RM NEW PATIENT EXTENDED SERVICE	15.1
90640	BRIEF CONSULTATIVE, FOLLOW-UP VISIT	4.3
90641	LIMITED CONSULT/FOLLOW-UP VISIT	4.9
90642	INTERMEDIATE CONSULT FOLLOW-UP VISIT	12.7
90643	EXTENDED CONSULT FOLLOW-UP	9.7
90699	UNLISTED MEDICAL SERVICE GENERAL	BR
90702	IMMUNIZATION/DIPTHERIA & TETANUS, DT	1.4
90703	IMMUNIZATION TETANUS TOXOID	1.4
90705	MEASLES VIRUS VACCINE, LIVE, ATTENUATED	.9
90719	IMMUNIZATION INJEC., DIPHTHERIA TOXOID	1.2
90724	INFLUENZA VIRUS VACCINE	1.9

PROC	SHORT DESCRIPTION	RUV
90726	INMMUNIZATION RABIES VACCINE	3.5
90742	SPECIFIC HYPERIMMUNE SERUM GLOBULIN	RNE
90782	THERAPEUTIC INJECTION OF MEDICATION	1.9
90784	INTRAUENOUSTHERAPEUTIC INJECTION	1.9
90788	INTRAMUSCULAR INJECTION OF ANTIBIOTIC	1.5
90799	UNLISTED THERAPEUTIC INJECTION	BR
90801	PSYCHIATRIC DIAGNOSTIC INTERVIEW	10.7
90830	PSYCHOLOGICAL TESTING BY PHYSICIAN W/ RPT /HR	12.7
90843	PSYCHOTHERAPY APPROX 20-30 MINUTES	7.8
90844	PSYCHOTHERAPY APPROX 45-50 MINUTES	13.6
90853	GROUP PSYCHOTHERAPY HOSP/OFFICE/HOME	6.6
90862	CHEMO MANAGE, RX USE AND REVIEW OF MEDICATION	5.8
90882	INTERPRETATION/EXPLANATION/ADVICE TO FAMILY	RNE
90887	REPORT OF PSYCHIATRIC STATUS	8.3
90889	UNLISTED PSYCHIATRIC SERVICE	BR
90902	BIOFEEDBACK TRAINING IN CONDUCTION DISORDER	8.2
90906	BIOFEEDBACK,REGULATION TEMP,&PERIPHERAL	5.5
90915	BIOFEEDBACK, OTHER	7.5
92225	OPHTHALMOSCOPY	5.4
92567	TYMPANOMETRY	1.8
92599	UNLISTED OTORHINOLAR YNGOLOGICAL, ORPROCEDURE	BR
93300	ECHOCARDIOGRAPHY M MODE COMPLETE	RNE
93305	ECHOCARDIOGRAPHY M MODE LIMITED	RNE
93307	ECHOCARDIOGRAPHY REAL TIME SCAN	48.1

PROC	SHORT DESCRIPTION	RUV
93760	THERMOGRAM, CEPHALIC	RNE
93762	THERMOGRAM, PERIPHERAL	RNE
93850	NON-INVASIVE STUDIES OF CEREBRAL ARTERIES	RNE
93870	NON-INVASIVE STUDIES OF CAROTID ARTERY	RNE
93890	LIMBARTERIAL STUDIES/UPPER EXTREMITY ARTERIES	RNE
93910	LIMB ARTERIAL STUDIES OF LOWER EXTREMITY	8.9
93950	VENOUS STUDY, LOWER EXTREMITY VEINS	8.1
93960	QUANTITATIVE VENOUS FLOW STUDIES LEV DOPPLER	RNE
94010	SPIROMETRY COMPLETE WITH REPORT	3.1
94060	BRONCHOSPASM EVAL BEFORE/AFTER BRONCHODIALATO	6.8
94150	VITAL CAPACITY TOTAL	RNE
94160	VITAL CAPACITY TOTAL AND TIMED	RNE
94200	MAXIMAL BREATHING CAPACITY	RNE
94240	FUNCTIONAL RESIDUAL CAPACITY INCL EQUIL SUBS	RNE
94350	NITROGEN WASHOUT CURVE CONTINUOUS	RNE
94375	RESPIRATORY FLOW VOLUME LOOP	3.1
94700	ANALYSIS ANTERIAL BLOODGAS	RNE
94720	CARBON MONOXIDE DIFFUSING CAPACITY ANY METHOD	RNE
94750	PULMONARY COMPLIANCE STUDY, ANY METHOD	RNE
95000	PERCUTANEOUS SCRATCH TESTS 1-30 TESTS EACH	RNE
95001	PERCUTANEOUS SCRATCH TESTS 31-60 TESTS EACH	RNE
95002	PERCUTANEOUS SCRATCH TESTS 61-90 TESTS EACH	RNE
95014	INTRACUTANEOUS TESTS W/ANTIBIOTICS 1-5	RNE
95020	INTRACUTANEOUS TESTS W/ALLERGENIC EXTRACTS	RNE

PROC	SHORT DESCRIPTION	RUV
95120	IMMUNOTHERAPY SINGLE ANTIGEN	RNE
95140	SUPERVISION/PROVISION MULT ANTIGEN SINGLE DOS	RNE
95145	STINGING INSECT SINGLE DOSE VIAL	RNE
95867	EMG CRANIAL NERVE SUPPLIED MUSCLES,UNILATERAL	RNE
95935	"H" REFLEX, BY ELECTRODIAGNOSTIC TESTING	9.7
95937	NEUROMUSCULAR JUNCT TEST REPETITIVE STIMULI	RNE
97010	PHYSICIAN MED RX 1 AREA HOT/COLD PACK	1.0
97012	PHYSICAL MED/TRACTION MECHANICAL	1.3
97014	ELECTRICAL STIMULATION (UNATTENDED)	1.6
97018	PHYSICIAN MED RX PARAFFIN BATH	RNE
97022	PHYSICIAN MED RX WHIRLPOOL	2.1
97024	PHYSICIAN MED RX DIATHERMY	1.2
97026	PHYSICIAN MED RX INFARED	.9
97039	UNLISTED MODALITY	BR
97110	PHYS MED RX INIT 30 MIN THERAPY EX	4.5
97118	PHYS MED RX 30 MIN ELECTRICAL STIMULATION MAN	1.6
97122	PHYS MED RX 30 MIN TRACTION MANUAL	RNE
97124	PHYS MED RX 30 MIN MASSAGE	1.2
97128	PHYS MED RX 30 MIN ULTRASOUND	1.9
97129	PHYSICAL THERAPY - RX PHONOPHORESIS	RNE
97139	PHYSICAL MEDICINE UNLISTED PROCEDURE	BR
97145	PHYS MED RX 1 AREA EACH ADDITIONAL 15 MINUTES	1.5
97700	OFFICE VISIT ONE TEST 30 MINUTES	4.7
97701	OFFICE VISIT ONE TEST EACH ADDTL 15 MINUTES	1.9

PROC	SHORT DESCRIPTION	RUV
97752	MUSCLE TESTING DURING ISOME/ISOKE EXERCISE	4.9
99000	COLLECTION/HANDLING/CONVEYANCE SPECIMEN OFFIC	1.3
99001	COLL/HAND/CONVEY SPEC TRANSFER HOME TO LAB	RNE
99002	COLLECTION/HANDLING/CONVEYANCE ORTH/PROSTH	1.5
99013	PHONE CALL CONSULTATION BRIEF	.5
99015	PHONE CALL CONSULTATION LENGTHY OR COMPLEX	BR
99024	POSTOPERATIVE FOLLOW UP CARE	RNE
99025	INITIAL VISIT NEW PT MINIMUN SURG MAJ	3.3
99056	OFFICE SERVICE OTHER LOCATION THAN PHYS OFFIC	5.8
99058	OFFICE SERVICES PROVIDED ON AN EMERGENCY BASI	5.8
99062	EM CARE NON HOSPITAL BASED PHYS ON PREMISES	2.1
99064	EM CARE NON HOSPITAL BASED PHYS OFF PREMISES	3.9
99075	MEDICAL TESTIMONY	RNE
99078	PHYSICIAN EDUCATIONAL SERVICES	RNE
99082	UNUSUAL TRAVEL	BR
99140	ANES, COMPLECATED BY EMERGENCY CONDITIONS	8.6
99150	PROLONGED PHYS DETENTION 30 MIN TO 1 HOUR	15.1
99151	PROLONGED PHYS DETENTION OVER 1 HOUR	23.3
99155	MEDICAL CONFERENCE W PT/REL APPROX 25 MIN	RNE
99160	CRITICAL CARE INITIAL EACH HOUR	26.8
99171	CRITICAL CARE SUBSEQUENT	4.9
99172	CRITICAL CARE LIMITED	8.6
99173	CRITICAL CARE INTERMEDIATE	RNE
99191	ASSEMBLY/OPERATION PUMP WITH OXYGEN PER 1/2 H	RNE

PROC	SHORT DESCRIPTION	RUV
99199	UNLISTED SPECIAL SERVICE OR REPORT	BR

ANESTHESIA SECTION

One unit of time equals 12 minutes.

Please refer to the American Society of Anesthesiologist's Relative Unit Guide.

SURGERY SECTION

PROC	SHORT DESCRIPTION	RUV
11041	DEBRIDEMENT SKIN FULL THICKNESS	RNE
11042	DEBRIDEMENT SKIN & SUBCUTANEOUS TISSUE	RNE
11043	DEBRIDEMENT SKIN/SUBCUTANEOUS TISS/MUSCLE	RNE
11044	DEBRIDEMENT SKIN/SUBCUT TISS/MUSCLE/BONE	RNE
11404	EXC BENIGN LESION TRUNK LIMBS 3-4 CM	RNE
11426	EXC BENIGN LESION EXTREMITIES OVER 4 CM	RNE
11760	RECONSTRUCTION NAIL BED SIMPLE	RNE
12020	TREATMENT OF SUPERFICIAL WOUND; SIMPLE	.4
13160	SECONDARY CLOSURE OF SURGICAL WOUND, EXTENSIV	RNE
14350	FILLETED FINGER/TOE FLAP INCL PREP RECIP SITE	RNE
15000	EXCISIONAL REPAIR BY FREE SKIN GRAFT	SV
15580	PRIMARY ATTACH CROSS FINGER PED FLAP INCL GRF	RNE
15781	ABRASION OF SKIN FOR REMOVAL OF SCARS ETC.	.6
15837	EXCISION, EXCESSIVE SKIN, FOREARM OR HAND	RNE
15931	EXCISION, DECULBITUS ULCER, SACRAL	RNE
15952	EXCISION DECUBITUS ULCER/W/REPAIR	RNE
16015	DRESSINGS/DEBRIDE INIT/SUBS W ANES MED/LARGE	RNE
20005	INCISION SOFT TISSUE ABSCESS DEEP/COMPLICATED	RNE
20804	REIMPLANTATION ARM INCOMPLETE	RNE
22379	HARRINGTON ROD TECHNIQUE	RNE
22555	ARTHRODESIS W DISKEC CERV ANT APPR AUTOG GRAF	13.7
22561	ARTHRODESIS W DISKEC LUMB POST APP AUTOG GRAF	17.6
22615	ARTHRODESIS W DISKEC CERV ANT APP AUTOG GRAFT	RNE
22720	LUMBAR POSTERIOR APPR ROD DISTRACTION W GRAFT	RNE

PROC	SHORT DESCRIPTION	RUV
22845	POST INSTRUMENTATION DWYER TECHNIQUE	RNE
22850	HARRINGTON ROD REMOVAL	RNE
23100	SHOULDER ARTHROTOMY FOR BIOPSY	RNE
23330	REMOVAL FOREIGN BODY SUBCUTANEOUS	RNE
23355	ARTHROSCOPY SHOULDER	RNE
23655	SHOULDER DISLOC SIMPLE REDUCTION W ANESTHESIA	1.9
24201	REMOVAL FOREIGN BODY DEEP	RNE
24354	FASCIOTOMY LAT/MED WITH STRIPPING	RNE
25020	DECOMPRESSION FASCIOTOMY FLEX/EXTEN COMPRMNT	RNE
25040	ARTHROTOMY WRIST EXPL DR REMOV FOREIGN BODY	RNE
25115	RADICAL EXCISION BURSA HAND/WRIST	RNE
25150	PARTIAL EXC BONE ULNA FOR OSTEOMYELITIS	RNE
25390	OSTEOPLASTY RADIUS OR ULNA SHORTENING	RNE
25505	TRMNT RADIAL SHAFT FX SIMP MANIP REDUCTION	RNE
25515	TRMNT RADIAL SHAFT FX SIMP/COMP OP REDUCTION	RNE
25545	TRMNT ULNAR SHAFT FX SIMP/COMP OP REDUCTION	RNE
25575	RADIAL & ULNAR SHAFT FX SIMP/COMP OP REDUCTN	RNE
25605	DISTAL RADIUS FX SIMPLE MANIP REDUCTION	2.0
25610	DISTAL RADIUS FX SIMP/COMP OPEN REDUCTION	RNE
25635	CARPAL BONE FX SIMPLE MANIP REDUCTION	RNE
26116	EXC BENIGN TUMOR DEEP/SUBFASCIAL/INTRAMUSC	RNE
26356	FLEXOR TENDON REPAIR NO MANS LAND	3.3
26433	EXTENSOR TENDON REPAIR W/O FREE GRAFT	RNE
26445	TENOLYSIS FINGER SINGLE	1.3

PROC	SHORT DESCRIPTION	RUV
26727	PHALANGEAL SHAFT FX W REDUCTION W FIXATION	RNE
26746	ARTICULAR FX SIMP/COMP OPEN REDUCTION	RNE
26775	DSLC INTERPHALANGEAL SIMPLE RED W ANESTHESIA	RNE
27088	REMOVAL FOREIGN BODY DEEP COMPLICATED	RNE
27301	INC & DRAIN DEEP ABSC/INFECT BURSA/HEMATOMA	RNE
27334	ARTHROTOMY KNEE FOR SYNOVECTOMY	RNE
27373	ARTHROSCOPY KNEE DIAGNOSTIC SEPARATE PROC	3.3
27374	ARTHROSCOPY,KNEE,SURGICAL SHAVING OR DRILLING	7.4
27377	ARTHROSCOPY KNEE W REMOVAL OF LOOSE BODY	6.5
27378	ARTHROSCOPY KNEE W PARTIAL MENISCECTOMY	8.2
27379	ARTHROSCOPY KNEE W PLICA/SHELF RESECTION	6.2
27410	SUTURE COLL OR CRUCI TORN LIG KNEE SECONDARY	RNE
27414	SUTURE COLL & CRUCI TORN LIG KNEE SECONDARY	RNE
27425	LATERAL RETINACULAR RELEASE	6.0
27447	ARTHROPLASTY KNEE MEDIAL & LATERAL COMPRTMNTS	RNE
27457	OSTEOTOMY PROX TIB UNI AFTER EPIPHYSIAL CLOSE	RNE
27758	TIBIAL SHAFT FX COMPLICATED	RNE
28193	REMOVAL FOREIGN BODY COMPLICATED	RNE
28296	HALLUX VALGUS CORRECTION W/METATARSAL OSTEOTO	RNE
28299	HALLUX VALGUS OTHER METHODS DOUBLE OSTEOTOMY	RNE
28315	SESAMOIDECTOMY FIRST TOE	RNE
28405	CALCANEAL FX CLOSED MANIPULATIVE REDUCTION	RNE
28406	CALCANEAL FX W MANIPULATION/SKEL FIXATION	RNE
29130	SPLINT FINGER STATIC	.1

PROC	SHORT DESCRIPTION	RUV
29260	STRAPPING ELBOW OR WRIST	RNE
29358	LONG LEG CAST BRACE	RNE
29530	STRAPPING KNEE	RNE
29540	STRAPPING ANKLE	.1
29550	STRAPPING TOES	RNE
30901	CAUTERIZATION NASAL HEMORRHAGE,ANT/SIMPLE UNI	RNE
31080	SINUSOTOMY FRONTAL OBLITERATIVE WO OSTEO FLAP	RNE
31645	ENDOSCOPY W/ASPIRATION TRACHEOBRONCHIAL	RNE
32020	THROACOSTOMY W/WATERSEAL (TUBE)	.6
33210	INSERTION/TEMP TRANS CARDIAC ELEC/PACEMAKER	RNE
35151	REPAIR FOR ANEURYSM POPLITEAL ARTERY	RNE
35256	REPAIR BLOOD VESSEL LOWER EXTREMITY	RNE
35266	REPAIR BLOOD VESSEL UPPER EXTREMITY	1.7
35761	EXPLORATION W/WO LYSIS OF ARTERY,OTHER VESSEL	RNE
36000	IV INTRODUCTION OF NEEDLE OR INTRACATHETER	RNE
36010	INTRODUCTION OF CATHETER, SUP. OR INFER. VENA	RNE
36600	ARTERIAL PUNCTURE	RNE
37720	LIGATION & DIV. VEINS UNILATERAL	RNE
37785	LIG, DIV &/OR EXCISE SEC VAROCOSE VEINS/ LEG	RNE
38115	REPAIR/RUPTURED SPLEEN W/OR WO PAR SPLENECTOM	RNE
43235	UPPER GASTROINTESTINAL ENDOSCOPY	RNE
45300	ENDOSCOPY, PROCTOSIGMOIDOSCOPY; DIAGNOSTIC	.2
45330	SIGMOIDOSCOPY, FLEXIBLE FIBEROPTIC	RNE
45560	REPAIR OF RECTOCELE	RNE

PROC	SHORT DESCRIPTION	RUV
46257	HEMORRHOIDECTOMY W/ FISSURECTOMY	RNE
49505	REP INGUINAL HERNIA AGE 5+ UNILATERAL	4.4
49506	REP INGUINAL HERNIA AGE 5+ BILATERAL	4.9
49530	REPAIR INGUINAL HERNIA INCARCERATED	RNE
49581	REPAIR UMBILICAL HERNIA OVER 5 YEARS	4.3
51726	CYSTOMETROGRAM, COMPLEX W/GAS	.6
53670	CATHETERIZATION; SIMPLE	.2
58720	SALPINGO-OOPHORECTOMY-COMP/PART-UNILAT/BILAT	RNE
61712	MICRODISSECTION,ITRACRANIAL OR SPINAL PROCED.	SV
62292	INJ CHEMONUCLEO SINGLE/MULT LUMB	11.7
63242	LAMINEC SPINAL LESION/LUMBAR	RNE
63655	LAMIN IMPL NEUROSTIM ELECT EPIDU	RNE
63685	INC SUBQ PLACE NEUROSTIM RECV DI	RNE
64413	NERVE BLOCK CERVICAL PLEXUS	RNE
64442	PARAVERT FACET LUMBAR/SINGLE	.5
64443	PARAVERT FACET LUMBAR/EA ADDT LEVEL	.5
64622	DESTR/PARAVERT FACET LUMBAR SINGLE	RNE
64623	DESTR/PARAVERT FACET LUMBAR/EA ADDT LEVEL	RNE
64830	MICRODISSEC REPAIR 50U ADD CHG	RNE
64890	NRV GRAFT SINGL HND/FT TO 4 CM	RNE
64896	NRV GRAFT MULT HND/FT MORE THAN 4 CM	RNE
64901	NRV GFT EA ADD NRV SING STRAND	RNE
66980	CAT EXT W/INTRAOCULAR IMPLANT	RNE
66984	EXTRA CAPSULAR CATARACT REMOVAL INSERT OF PRO	RNE

PROC	SHORT DESCRIPTION	RUV
66985	CAT EXT/SECONDARY TO EARLIER CAT EXT	RNE
67035	VITRECTOMY MECH PARS PLANNA APP	RNE
69433	TYMPANOSTOMY W/TUBE LOCAL ANES	RNE
69437	TYMPANOSTOMY W/TUBE GEN ANES BILATERAL	RNE
69633	TYMP W/O MAST/W/CHAIN RECONSTR W/PROSTHESIS	RNE

RADIOLOGY - PROFESSIONAL COMPONENT SECTION

PROC	SHORT DESCRIPTION	RUV
70200	RADIOLOGIC EXAM ORBITS COMP 4 VIEWS	18.0
70355	ORTHOPANTOGRAM	RNE
70450	CAT SCAN HEAD W/O CONTRAST MEDIA	57.6
70460	CAT SCAN CEREBRAL LIM/CONTRAST	42.7
70470	CAT SCAN CERE WO + CONT	73.2
70480	CAT ORBIT-SELLA-POST FOS WO CONTRAST MATERIAL	RNE
71101	RADIOLOGIC EXAM RIBS INCL PA CHEST MIN 3 VWS	14.0
71111	RADIOLGC EXAM RIBS BILAT INC PA CHST MIN 4 VW	RNE
71250	CAT SCAN THORAX W/O IV CONTRAST	RNE
71260	CAT SCAN THORAX W/INTRAVENOUS CONTRAST	RNE
71270	CAT SCAN THORAX W/O IV CONT THEN IV CONT SECT	RNE
72020	RADIOLOGIC EXAM SPINE SINGLE VIEW SPECIFY LVL	7.3
72072	RADIOLOGIC EXAM SPINE THOR AP LAT INC SWIM VW	14.8
72125	CAT CERVICAL SPINE WO CONTRAST	55.3
72128	CAT SCAN, THORAICIC SPINE W/O CONTRAST	54.6
72131	CAT SCAN LUMBAR SPRINE W/O CONTRAST MATERIAL	54.9
72132	CAT SCAN/W CONTRAST MATERIAL	52.1
72140	COMPUTERIZED AXIAL TOMOGRAPHY, MAGNETIC RESON	RNE
72192	COMP TOMOGRAPHY PELVIS W/O CONTRAST	RNE
72200	RADIOLOGIC EXAM SACROILIAC JOINTS LIMITED	10.1
72240	MYELOGRAPHY CERVICAL;SUPERVISION & INTRPRTION	57.0
72241	MYELOGRAPHY CERV COMP PROC INJ & PC	129.3
72255	MYELOGRAPHY THORACIC TOTAL	RNE
72256	MYELOGRAPHY THORACIC COMPLETE PROCEDURE	RNE

PROC	SHORT DESCRIPTION	RUV
72265	MYELOGRAPHY LUMBOSACRAL	37.9
72266	MYELOGRAPHY LUMBOSACRAL COMPLETE PROCEDURE	125.0
72271	MYELOGRAPHY ENTIRE SPINE COMPLETE PROCEDURE	151.6
72295	DISCOGRAPHY LUMBAR COMPLETE	RNE
72296	DISCOGRAPHY LUMBAR COMPLETE PROCEDURE	RNE
73041	RADIOLOGIC EXAM SHOULDER ARTH/COMP PROC	44.2
73116	RADIOLOGIC EXAM WRIST ARTH/COMP PROC	RNE
73200	COMP TOMOGRAPHY UPPER EXT W/O CONTRAST	54.6
73526	RADIOLOGIC EXAM HIP COMPLETE PROCEDURE	RNE
73531	RADIOLOGIC EXAM HIP DURING SURGERY ADD STDY	RNE
73540	RADIOLOGIC EXAM;FEMUR ANTEROPOSTERIOR	RNE
73562	RADIOLOGIC EXAM KNEE AP LAT OBLQ MIN 3 VIEWS	8.8
73564	RADIOLOGIC EXAM KNEE COMP TUNN STANDING	10.7
73581	RADIOLOGIC EXAM KNEE ARTH/COMP PROC	53.7
73700	COMP TOMOG LOWER EXT W/O CONTRAST	20.4
74150	COMP TOMOG ABD/W/O IV CONTRAST	63.4
74160	COMP TOMOG ABD W IV CONTRAST	67.1
74170	COMPT TOMOG W/O IV CONT FLLWD BY IV CONT	66.3
74240	RADIOLOGIC EXAM UPPER GI TRACT W/O KUB	29.7
74241	RADIOLOGIC EXAM UPPER GI TRACT W KUB	RNE
74246	RADIOLOGIC EXAM GI UPPER AIR W/WO GLUCO DELYD	RNE
74431	CYSTOGRAPHY COMPLETE PROCEDURE	RNE
74451	URETHROCYSTOGRAPHY RETROGRADE COMPLETE PROC	RNE
75606	AORTA & ARTERIES, COMPLETE PROCEDURE	RNE

PROC	SHORT DESCRIPTION	RUV
75651	ANGIOGRAPHY, CERVICS CEREBRAL, COMPL PROCEDUR	RNE
75657	ANGIOGRAPHY, CERVICO CEREBRAL 3 OR 4 VESSELS,	RNE
75669	ANGIO CAR/CEREB UNI/CATHETER COMP PROCEDURE	RNE
75671	ANGIOGRAPHY CAROTID CEREBRAL BILATERAL	RNE
75712	ANGIOGRAPHY EXTREMITY BY SERIALOGRAPHY COMPLE	RNE
75820	VENOGRAPHY EXTREMITY UNILATERAL	27.4
75821	VENOGRAPHY EXTREMITY UNILAT COMP PROC	38.6
75823	VENOGRAPHY EXTREMITY BILAT COMP PROC	47.4
76080	FISTULA OR SINUS TRACT STUDY	RNE
76150	MISC ZERORADIOGRAPHY	11.6
76300	THEROGRAM	RNE
76375	COMPUTERIZED TOMOGRAPHY, RADIATION THERAPY	RNE

RADIOLOGY - TOTAL SECTION

PROC	SHORT DESCRIPTION	RUV
70015	CISTERNOGRAPHY POS CONT COMPLETE	RNE
70200	RADIOLOGIC EXAM ORBITS COMP 4 VIEWS	RNE
70332	TEMPOROMANDIBULAR ARTHROGRAPHY	RNE
70450	CAT SCAN HEAD W/O CONTRAST MEDIA	RNE
70470	CAT SCAN CERE WO + CONT	22.0
71101	RADIOLOGIC EXAM RIBS INCL PA CHEST MIN 3 VWS	5.5
72020	RADIOLOGIC EXAM SPINE SINGLE VIEW SPECIFY LVL	2.6
72072	RADIOLOGIC EXAM SPINE THOR AP LAT INC SWIM VW	5.2
72125	CAT CERVICAL SPINE WO CONTRAST	8.8
72128	CAT SCAN, THORAICIC SPINE W/O CONTRAST	8.4
72131	CAT SCAN LUMBAR SPRINE W/O CONTRAST MATERIAL	8.8
72132	CAT SCAN/W CONTRAST MATERIAL	RNE
72200	RADIOLOGIC EXAM SACROILIAC JOINTS LIMITED	2.0
72240	MYELOGRAPHY CERVICAL;SUPERVISION & INTRPRTION	RNE
72241	MYELOGRAPHY CERV COMP PROC INJ & PC	22.5
72255	MYELOGRAPHY THORACIC TOTAL	RNE
72256	MYELOGRAPHY THORACIC COMPLETE PROCEDURE	RNE
72265	MYELOGRAPHY LUMBOSACRAL	5.6
72266	MYELOGRAPHY LUMBOSACRAL COMPLETE PROCEDURE	20.0
72271	MYELOGRAPHY ENTIRE SPINE COMPLETE PROCEDURE	21.0
72295	DISCOGRAPHY LUMBAR COMPLETE	RNE
72296	DISCOGRAPHY LUMBAR COMPLETE PROCEDURE	RNE
73041	RADIOLOGIC EXAM SHOULDER ARTH/COMP PROC	9.9
73116	RADIOLOGIC EXAM WRIST ARTH/COMP PROC	RNE

PROC	SHORT DESCRIPTION	RUV
73200	COMP TOMOGRAPHY UPPER EXT W/O CONTRAST	RNE
73540	RADILOLGIC EXAM;FEMUR ANTEROPOSTERIOR	RNE
73562	RADIOLOGIC EXAM KNEE AP LAT OBLQ MIN 3 VIEWS	4.6
73564	RADIOLOGIC EXAM KNEE COMP TUNN STANDING	4.7
73581	RADIOLOGIC EXAM KNEE ARTH/COMP PROC	8.3
73615	RADIOLOGIC EXAM ANKLE ARTHROGRAPHY TOTAL	RNE
74150	COMP TOMOG ABD/W/O IV CONTRAST	RNE
74170	COMPT TOMOG W/O IV CONT FLLWD BY IV CONT	RNE
74240	RADIOLOGIC EXAM UPPER GI TRACT W/O KUB	8.4
75631	AORTOGRAM	RNE
75712	ANGIOGRAPHY EXTREMITY BY SERIALOGRAPHY COMPLE	RNE
75820	VENOGRAPHY EXTREMITY UNILATERAL	RNE
75821	VENOGRAPHY EXTREMITY UNILAT COMP PROC	8.8
75827	VENOGRAPHY CAVAL SUPERIOR W SERIALGRAPHY	RNE
76137	RADIOLOGIC EXAM AFTER REGULAR HOURS	RNE
76150	MISC, ZERORADIOGRAPHY	RNE
76350	SUBTRACTION IN CONJUNCTION W/CONTRAST STUDY	RNE
76361	COMPUTERIZED TOMOGRAPHY NEEDLE BIOPSY, CMPLT	RNE

PATHOLOGY SECTION

PROC	SHORT DESCRIPTION	RUV
81002	URINALYSIS ROUTINE W/O MICROSCOPY	5.2
82251	BILIRUBIN BLOOD TOTAL & DIRECT	RNE
82252	BILIRUBIN FECES QUALITATIVE	RNE
82270	BLOOD FECES OCCULT SCREENING	RNE
82372	CARBAMAZEPINE SERUM	RNE
82546	CREATINE AND CREATININE	RNE
82607	CYANOCOBALAMIN RIA	20.0
82756	FREE THYROXINE INDEX T-7	RNE
82977	GLUTAMYL TRANSPEPTIDASE GAMMA GGT	RNE
83018	CHROMATOGRAPHY DEAE COLUMN	RNE
83036	HEMOGLOBIN GLYCOSYLATED A1C	RNE
83545	IRON AUTOMATED	RNE
84045	DIPHENOLHYDANTOIN DILANTIN BLOOD	20.0
84180	PROTEIN URINE QUANTITATIVE 24 HR SPECIMEN	RNE
84200	PROTEIN SPINAL FLD ELECTROPHORETIC FRAC/QUANT	RNE
84435	THYROXINE,T-4 CPB OR RESIN UPTAKE	10.8
84436	THYROXINE TRUE TT-4 RIA	RNE
84455	THYROTROPIN RELEASING FACTOR PLUS LONG ACTING	RNE
84478	TRIGLYCERIDES BLOOD	RNE
84480	TRIIODOTHYRONINE TRUE TT-3 RIA	RNE
84560	URIC ACID URINE	RNE
85027	HEMOGRAM AUTOMATED WITH PLATELET COUNT	RNE
85028	HEMOGRAM AUTO & DIFF WBC COUNT W/PLATLET CNT	RNE
85544	LUPUS ERYTHEMATOSUS LE CELL PREP	RNE

PROC	SHORT DESCRIPTION	RUV
86038	ANTINUCLEAR ANTIBODIES ANA, RIA	RNE
86423	RADIOIMMUNOSORBENT TEST RIST IGE QUANTITATIVE	RNE
86430	RHEUMATOID FACTOR ALTEX FIXATION	11.2
87083	CULTURE SCREENING BY KIT MULTIPLE ORGANISMS	RNE
89399	UNLISTED MISCELLANEOUS PATHOLOGY TEST	BR

DENTAL SECTION

Please note dental procedures new codes.

PROC	SHORT DESCRIPTION	RUV
00110	INITIAL ORAL EXAMINATION	1.7
00130	EMERGENCY ORAL EXAMINATION	2.1
00210	INTRAORAL - COMPLETE SERIES	4.3
00220	INTRAORAL-PERIAPICAL SINGLE,FIRST FILM	1.0
00230	INTRAORAL-PERIAPICAL EACH ADDTNL FILM	.6
00321	TEMPOROMANDIBULAR JOINT FILM	6.4
00330	PANORAMIC-MAXILLA & MANDIBLE FILM	4.3
00460	PULP VITALITY TESTS	.7
00470	DIAGNOSTIC CASTS	BR
00471	DIAGNOSTIC PHOTOGRAPHS	BR
01110	PRUPHYLAXIS-ADULT	RNE
02140	AMALGAM-ONE SURFACE,PERMANENT	2.1
02150	AMALGAM-TWO SURFACES,PERMANENT	RNE
02160	AMALGAM-THREE SURFACES,PERMANENT	6.2
02161	AMALGAM-FOUR OR MORE SURFACES,PERMANENT	RNE
02190	PIN RETENTION-EXCLUSIVE OF AMALGAM	1.4
02210	SILICATE CEMENT PER RESTORATION	RNE
02330	COMPOSITE RESIN-ONE SURFACE	3.6
02331	COMPOSITE RESIN-TWO SURFACES	5.7
02332	COMPOSITE RESIN-THREE SURFACES	7.9
02334	PIN RETENTION-EXCLUSIVE OF COMPOSITE RESIN	1.4
02335	COMPOSITE RESIN INVOLVING INCISAL EDGE	6.7
02340	ACID ETCH FOR RESTORATIONS	3.9
02710	PLASTIC ACRYLIC	RNE

PROC	SHORT DESCRIPTION	RUV
02740	PORCELAIN	40.0
02750	PORCELAIN WITH GOLD	42.9
02751	PORCELAIN WITH NONPRECIOUS METAL	42.0
02752	PORCELAIN WITH SEMIPRECIOUS METAL	45.0
02790	GOLD FULL CAST	42.9
02792	SEMIPRECIOUS METAL FULL CAST	RNE
02840	TEMPORARY FRACTURED TOOTH	RNE
02891	CAST POST & CORE PLUS CROWN	12.1
02892	PREFABRICATED POST/CORE ADDITION CROWN	7.1
02950	CROWN BUILDUP-INCLUDING PINS	6.7
03220	VITAL PULPOTOMY EXCLUDES FINAL RESTORATION	RNE
03310	ROOT CANAL THERAPY	18.6
03320	ROOT CANAL THERAPY, TWO CANALS	RNE
03330	ROOT CANAL THERAPY - 3 CANALS	33.6
03960	BLEACHING OF DISCOLORED TOOTH	RNE
03999	UNSPECIFIED ENDODONTIC PROCEDURE	BR
04321	DIAGNOSTIC SPLINT TMJ	10.7
04330	OCCLUSAL ADJUSTMENT (LIMITED)	4.3
04331	OCCLUSAL ADJUSTMENT COMPLETE	8.2
04360	SPECIAL PERIODONTAL APPL INCLDNG OCCLUSAL GRD	BR
05110	COMPLETE UPPER	RNE
05120	COMPLETE LOWER	64.9
05140	IMMEDIATE LOWER	RNE
05211	UPPER-WITHOUT CLASPS ACRYLIC BASE	RNE

PROC	SHORT DESCRIPTION	RUV
05212	LOWER-WITHOUT CLASPS ACRYLIC BASE	RNE
05216	UPPER-TWO CHROME CLASPS W RSTS/ACRYL BSE	RNE
05230	LOWER-GOLD LINGUAL BAR/TWO CLSPS ACRYL BSE	RNE
05241	LOWER-CHROME LINGUAL BAR/TWO CLSPS CST BSE	RNE
05261	UPPER-CHROME PALATAL BAR/TWO CLASPS/CAST BSE	RNE
05291	FULL CAST PARTIAL W TWO GOLD CLASPS UPPER	RNE
05292	FULL CAST PARTIAL W TWO CHROME CLASPS UPPER	RNE
05294	FULL CAST PARTIAL W TWO CHROME CLASPS LOWER	RNE
05610	RPR BROKEN COMPLETE/PARTIAL DNTRE NO TEETH	RNE
05620	RPR BROKEN COMPLETE/PARTIAL DNTRE 1 TOOTH	RNE
05640	REPLACE BROKEN TOOTH-DENTURE NO OTHR RPRS	RNE
05650	ADD TOOTH/PARTIAL-EACH TOOTH NO CLSP/ABTMT	RNE
05660	ADD TOOTH/PARTIAL-EACH TOOTH W CLSP/ABTMT	RNE
05699	UNSPECIFIED REMOVABLE DENTURE REPAIR PRCDRE	BR
05710	DUPLICATE UPPER OR LOWER COMPLETE DENTURE	BR
05720	DUPLICATE UPPER OR LOWER PARTIAL DENTURE	BR
06210	BRIDGE PONTICS-CAST GOLD	RNE
06211	BRIDGE PONTICS-NONPRECIOUS	RNE
06212	BRIDGE PONTICS-CAST SEMI-PRECIOUS	RNE
06220	BRIDGE PONTICS-SLOTTED FACING	RNE
06240	BRIDGE PONTICS-PORCELAIN FUSED TO GOLD	43.7
06241	BRIDGE PONTICS-PRCLN FUSED TO NON-PRCS METAL	31.4
06242	BRIDGE PONTICS-PRCLN FUSED TO SEMIPRCH MTL	40.7
06699	UNSPECIFIED FIXED PROSTHODONTIC REPAIRS	BR

PROC	SHORT DESCRIPTION	RUV
06720	PLASTIC PROCESSED TO GOLD	RNE
06721	PLASTIC PROCESSED TO NONPRECIOUS METAL	RNE
06740	PORCELAIN	45.6
06750	PORCELAIN FUSED TO GOLD	41.4
06751	PORCELAIN FUSED TO NON-PRECIOUS METAL	32.1
06752	PORCELAIN FUSED TO SEMI-PRECIOUS METAL	39.3
06780	GOLD 3/4 CAST	RNE
06790	GOLD FULL CAST	RNE
06960	DAVIEL PIN - METAL	RNE
06999	UNSPECIFIED PROSTHETIC SRV (EXC REPRS)	BR
07110	EXTRACTION SINGLE TOOTH	3.6
07120	EXTRACTION EACH ADDITIONAL TOOTH	3.6
07210	EXTRACTION OF TOOTH - ERUPTED	6.6
08360	REMOVABLE APPLIANCE THERAPY	BR
08370	ORTHODONTIC APPLIANCE/FIXED TMJ	BR
08999	UNSPECIFIED ORTHODONTIC TREATMENT	BR
09200	ANESTHESIA	BR
09610	THERAPEUTIC DRUG INJECTION	BR
09630	OTHER DRUGS/INJECTIONS	BR
09930	COMPLICATIONS POST SURGICAL	BR
09998	UNLISTED MISC SERVICE PROCEDURE	BR
09999	UNSPECIFIED	BR

APPENDIX A

MEDICAL SERVICE PROVIDER FORMS

EXHIBIT 1 - ATTENDING PHYSICIAN'S FIRST REPORT AND BILL FOR INITIAL TREATMENT (PF 462)

MONTANA DIVISION OF WORKERS' COMPENSATION

ATTENDING PHYSICIAN'S FIRST REPORT and BILL for INITIAL TREATMENT

DATE OF RECEIPT

OWC USE ONLY

DWC USE ONLY

ACCIDENT NUMBER ▶ | DOCUMENT NUMBER ▶

POLICY NUMBER ▶ | PAYEE NUMBER ▶

Complete form in full – All questions must be answered. Form must be mailed to the employer's workers' compensation insurer or the Division of Workers' Compensation, 5 South Last Chance Gulch, Helena, Montana 59601, within 48 hours after first examination. IMPORTANT Please be sure to give the correct spelling of the name and address of the patient and employer.

Employee and Employer

Full name of patient _____ (Last / First / Mi) Occupation _____

Patient's mailing address _____ (P.O. Box or Street / City / State) age ____ sex ____

Name of Employer _____ Firm Name _____

Employer's address _____ (P.O. Box or Street / City / State / Zip)

Accident

Date of accident _____ 19 ____

State in patient's own words, how accident occurred _____

Treatment

Date first treatment rendered _____ 19 ____ Hour _____ A.M. P.M. Place _____

Name of hospital _____ Was private room ordered by you? ☐ Yes ☐ No

Diagnosis and description of injury _____

X ray findings _____

Describe treatment _____

SECTION BELOW MUST BE COMPLETED BEFORE CHARGES CAN BE PAID

Disability

Will patient be unable to work 5 days or more as a result of this injury? _____ ☐ Yes ☐ No

What date did patient cease work? _____ 19 ____

Estimate how long patient will be off work due to this injury _____ week(s)

Will injury result in permanent disability? _____ ☐ Yes ☐ No

Is patient suffering from a condition which pre-existed this accident? _____ ☐ Yes ☐ No

If yes, describe condition _____

Is present condition due to work related accident? _____ ☐ Yes ☐ No

BILL FOR SERVICES

DATE OF SERVICE	OWC USE	PROCED / MODIFIER	NO. UNITS	DESCRIPTION – LIST EACH PROCEDURE SEPARATELY	AMOUNT	LN
						01
						02
						03
						04
						05
						06
				TOTAL ▶		

IS THIS A FINAL BILLING? ☐ Yes ☐ No If no, date of next appointment _____

_____ (Doctor's name here) _____ (Montana License Number)

Social Security Number or IRS Number of Doctor _____

Signature _____ Date _____

Street or P. O. Box _____ Phone No. _____

City and State _____ Zip Code _____

All items should be billed at amounts customarily charged However, fees in excess of those authorized by the Division of Workers' Compensation will not be paid. After acceptance of liability by the insurer, the provider is prohibited by law from seeking payment from the patient.

DWC MIS PF-462 (Rev 10/83)

OS 269/270

EXHIBIT 2 - ATTENDING CHIROPRACTOR'S FIRST REPORT AND BILL FOR INITIAL TREATMENT (PF 463)

MONTANA DIVISION OF WORKERS' COMPENSATION

ATTENDING CHIROPRACTOR'S FIRST REPORT and BILL for INITIAL TREATMENT

INSURER OR DIVISION COPY

DATE OF RECEIPT

OWC USE ONLY

DWC USE ONLY

ACCIDENT NUMBER ▶		DOCUMENT NUMBER ▶	
POLICY NUMBER ▶		PAYEE NUMBER ▶	

Complete form in full – All questions must be answered. Form must be mailed to the employer's workers' compensation insurer or the Division of Workers' Compensation, 5 South Last Chance Gulch, Helena, Montana 59601, within 48 hours after first examination. IMPORTANT. Please be sure to give the correct spelling of the name and address of the patient and employer.

Employee and Employer

Full name of patient _____ Occupation _____
(Last, First, MI)

Patient's mailing address _____ age ____ sex ____
(P.O. Box or Street, City, State)

Name of Employer _____ Firm Name _____

Employer's address _____
(P.O. Box or Street, City, State, Zip)

Accident

Date of accident _____ 19 ____

State in patient's own words, how accident occurred _____

Treatment

Present Subjective Complaints _____

Has this patient been under the care of another health care provider for this injury? ☐ Yes ☐ No

Date of first treatment _____ 19 ____ Hour ____ A.M. P.M.

Clinical diagnosis or description of injury _____

Is this condition predominantly unilateral? If yes, please indicate ____ right ____ left

X-ray findings _____

Was this case a referral to you? ☐ Yes ☐ No If yes, by whom? _____

Have you consulted with previous doctors concerning this case? ☐ Yes ☐ No

Have you secured permission from the insurer to treat? ☐ Yes ☐ No . If yes, from ____ to ____ (date)

Who granted permission? _____ Date _____

SECTION BELOW MUST BE COMPLETED BEFORE CHARGES CAN BE PAID

Disability

Will patient be unable to work for more than five days as a result of this injury? ☐ Yes ☐ No

Date last worked _____ 19 ____

In your opinion, was the accident the principal cause of these symptoms? ☐ Yes ☐ No

If no, please describe _____

BILL FOR SERVICES

DATE OF SERVICE	DWC USE	PROCED./ MODIFIER	NO UNITS	DESCRIPTION – LIST EACH PROCEDURE SEPARATELY	AMOUNT	LN
						01
						02
						03
						04
						05
						06
				TOTAL ▶		

IS THIS A FINAL BILLING? ☐ Yes ☐ No If no, date of next appointment _____

_____ _____
(Doctor's name here) (Montana License Number)

Social Security Number or IRS Number of Doctor _____

Signature _____ Date _____

Street or P. O. Box _____ Phone No _____

City and State _____ Zip Code _____

All items should be billed at amounts customarily charged However, fees in excess of those authorized by the Division of Workers' Compensation will not be paid After acceptance of liability by the insurer, the provider is prohibited by law from seeking payment from the patient.

OWC MIS PF 463 (Rev 10/83)

EXHIBIT 3 - CHIROPRACTOR'S SUPPLEMENTAL REPORT (PF 464)

MONTANA DIVISION OF WORKERS' COMPENSATION

CHIROPRACTOR'S SUPPLEMENTAL REPORT

INSURER OR DIVISION COPY

DATE OF RECEIPT

DWC USE ONLY

DWC USE ONLY			
ACCIDENT NUMBER ▶		DOCUMENT NUMBER ▶	
POLICY NUMBER ▶		PAYEE NUMBER ▶	

INSTRUCTIONS This supplemental report is to be submitted at the end of the first 15 days and every 30 days thereafter during the treatment period.

Employee and Employer

Full name of patient _____ (Last / First / MI) Occupation _____

Patient's mailing address _____ (P.O. Box or Street / City / State) age ____ sex ____

Name of Employer _____ Firm Name _____

Employer's address _____ (P.O. Box or Street / City / State / Zip)

Accident

Date of accident _____ 19____

Is the Patient still under treatment? ☐ Yes ☐ No

Has the Patient returned to work? ☐ Yes ☐ No Date _____

Is this a reopening of a prior treated accident? ☐ Yes ☐ No If yes, explain _____

Treatment Status

Indicate Status of Patient's Physical Condition: (add narrative report, if desired)

☐ Acute ☐ Chronic Reoccurring ☐ Patient failed to return

☐ Moderate ☐ Asymptomatic ☐ Dismissed with residual

☐ Mild ☐ Requesting additional Treatment Time

Date last treated _____ Date of next appointment _____

Anticipated Frequency of treatment _____ Estimated healing period _____

Present subjective complaints _____

Present objective findings _____

Has this condition been aggravated during the course of treatment? ☐ Yes ☐ No

If yes, please explain _____

Describe any conditions or findings not previously found or reported _____

Do you anticipate recovery to a preinjury status? ☐ Yes ☐ No If no, why _____

BILL FOR SERVICES

DATE OF SERVICE	DWC USE	PROCED / MODIFIER	NO. UNITS	DESCRIPTION – LIST EACH PROCEDURE SEPARATELY	AMOUNT	LN
						01
						02
						03
						04
						05
						06
				TOTAL ▶		

IS THIS A FINAL BILLING? ☐ Yes ☐ No If no, are you requesting permission to treat longer than 30 days? ____

_____ (Doctor's name here) _____ (Montana License Number)

Social Security Number or IRS Number of Doctor _____

Signature _____ Date _____

Street or P. O. Box _____ Phone No. _____

City and State _____ Zip Code _____

All items should be billed at amounts customarily charged. However, fees in excess of those authorized by the Division of Workers' Compensation will not be paid. After acceptance of liability by the insurer, the provider is prohibited by law from seeking payment from the patient.

DWC-MIS PF 464 (New 10/83)

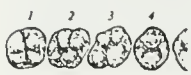
EXHIBIT 4 - ATTENDING DENTIST'S FIRST REPORT AND BILL FOR INITIAL TREATMENT (PF 465)

NOTICE

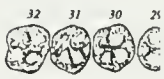
Dental fees are paid only for conditions shown to be due to the injury covered by the claim

The dental fees are based

On Chart No 1, indicate w
below, describe the conditions

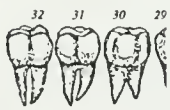


1



ON CHART NO 2, DEMONSTRA

2



DESCRIPTION OF THE WORK T

MONTANA DIVISION OF WORKERS' COMPENSATION

ATTENDING DENTIST'S FIRST REPORT and BILL for INITIAL TREATMENT

DATE OF RECEIPT

DWC USE ONLY

DWC USE ONLY

ACCIDENT NUMBER ▶ | DOCUMENT NUMBER ▶

POLICY NUMBER ▶ | PAYEE NUMBER ▶

Complete form in full – All questions must be answered Form must be mailed to the employer's workers compensation insurer or the Division of Workers' Compensation, 5 South Last Chance Gulch, Helena Montana 59601, within 48 hours after first examination IMPORTANT Please be sure to give the correct spelling of the name and address of the patient and employer

Employee and Employer

Full name of patient _____ (Last / First / Mi) Occupation _____

Patient's mailing address _____ (P.O. Box or Street / City / State) age ____ sex ____

Name of Firm and/or Employer _____

Employer's address _____ (P.O. Box or Street / City / State / Zip)

Accident

Date of accident _____ 19 ____

State in patient's own words, how teeth were injured _____

Number of teeth: _____ fractured _____ loosened _____ knocked out

Treatment

Date first treatment rendered _____ 19 ____ Hour _____ A M / P M Place _____

Name of hospital _____ Was private room ordered by you? ☐ Yes ☐ No

Diagnosis and description of injury _____

Dentist's Findings _____

X-ray Findings: _____

Describe initial or emergency treatment _____

Dentures to be replaced must have prior approval. If treatment plan is over $200.00
Panoramic and/or Periapical X-rays of injured teeth must be enclosed, and prior approval is required.

MARK CLEARLY ON CHARTS ON REVERSE SIDE OF THIS REPORT ALL TEETH INJURED

BILL FOR SERVICES

DATE OF SERVICE	DWC USE	PROCED / MODIFIER	NO. UNITS	DESCRIPTION – LIST EACH PROCEDURE SEPARATELY	AMOUNT	LN
						01
						02
						03
						04
						05
						06
						07
						08
						09
						10
						11
						12
				TOTAL ▶		

IS THIS A FINAL BILLING? ☐ Yes ☐ No If no, date of next appointment _____

_____ (Doctor's name here) _____ (Montana License Number)

Social Security Number or IRS Number of Doctor _____

Signature _____ Date _____

Street or P. O. Box _____ Phone No _____

City and State _____ Zip Code _____

All items should be billed at amounts customarily charged However, fees in excess of those authorized by the Division of Workers' Compensation will not be paid. After acceptance of liability by the insurer, the provider is prohibited by law from seeking payment from the patient.

DWC MIS PF 465 (New 10/83)

EXHIBIT 5 - PHYSICAL THERAPIST'S INITIAL REPORT AND CLAIM FOR SERVICES (PF 466)

MONTANA DIVISION OF WORKERS' COMPENSATION

PHYSICAL THERAPIST'S INITIAL REPORT and CLAIM for SERVICE

DATE OF RECEIPT

DWC USE ONLY

DWC USE ONLY

ACCIDENT NUMBER ▶		DOCUMENT NUMBER ▶	
POLICY NUMBER ▶		PAYEE NUMBER ▶	

Complete form in full – All questions must be answered. Form must be mailed to the employer's workers' compensation insurer or the Division of Workers' Compensation, 5 South Last Chance Gulch, Helena, Montana 59601, within 48 hours after first examination. IMPORTANT: Please be sure to give the correct spelling of the name and address of the patient and employer.

GENERAL INFORMATION

Full name of patient _____ (Last / First / Mi) Date of accident _____

Patient's mailing address _____ (P.O. Box or Street / City / State) age _____ sex _____

Name of Employer _____ Firm Name _____

Employer's address _____ (P.O. Box or Street / City / State / Zip)

Attending Physician _____ Nature of Injury _____

EVALUATION AND TREATMENT PLAN

COPY OF PHYSICIAN'S REFERRAL MUST BE ATTACHED.

EVALUATION:

IMPRESSION:

RECOMMENDATION:

ATTACH BILLING FOR SERVICES IN THE FOLLOWING FORMAT

DATE OF SERVICE	DWC USE	PROCED / MODIFIER	NO. UNITS	DESCRIPTION – LIST EACH PROCEDURE SEPARATELY	AMOUNT	LN
						01
						02
						03
				TOTAL ▶		

IS THIS A FINAL BILLING? ☐ Yes ☐ No If yes, attach exit report.

_____ (Therapist's name here) _____ (Montana License Number)

Social Security Number or IRS Number of Therapist _____

Signature _____ Date _____

Street or P.O. Box _____ Phone No. _____

City and State _____ Zip Code _____

All items should be billed at amounts customarily charged. However, fees in excess of those authorized by the Division of Workers' Compensation will not be paid. After acceptance of liability by the insurer, the provider is prohibited by law from seeking payment from the patient.

DWC-MIS PF-466 (New 12/83)

DS 270

EXHIBIT 6 - PHARMACIST'S CLAIM FOR SUPPLIES (PF 472)

HOW TO COMPLETE THIS FORM

CLAIMANT – Enter First, Middle Initial and Last Name of Patient (Claimant).

DAT
EMP
DOC
EMP
OBA
PHY
DAT
Rx N
*NAT
*BRA
DES
*NEW
*QUA
PRIC
CER
*NC
To
wa
cla
If

MONTANA DIVISION OF WORKERS' COMPENSATION

PHARMACIST'S CLAIM FOR SUPPLIES

DATE OF RECEIPT

DWC USE ONLY

DWC USE ONLY

ACCIDENT NUMBER ▶ | DOCUMENT NUMBER ▶

POLICY NUMBER ▶ | PAYEE NUMBER ▶

DIRECTIONS: *COMPLETE THIS FORM IN ITS ENTIRETY BY PRINTING IN INK OR USING A TYPEWRITER. DETAILED INSTRUCTIONS ARE ON THE BACK.*

Claimant _____ Date of Injury _____ 19___

Employer Name _____ Doctor _____

Employer Address _____

DBA or Commercial Name _____ DWC USE FOR PHYSICIAN ID ▶

DATE OF SALE MO-DAY-YR	Rx NUMBER	NATIONAL DRUG CODE	BRAND CODE	DESCRIPTION	NEW OR REF.	QUANTITY REF. NO.	QUANTITY Units	PRICE		LN NO
										01
										02
										03
										04
										05
										06
										07
										08
										09
										10
										11
										12
				TOTAL ➡						

CERTIFICATION – I certify that the above is a correct statement of account.

Pharmacy _____ Address _____ Tax ID _____

Signature _____ Title _____ Date _____

IMPORTANT: *PAYMENT CANNOT BE MADE ON REFILLS THAT ARE OLDER THAN 30 DAYS FROM THE DATE OF LAST SALE WITHOUT A RENEWAL PRESCRIPTION FROM THE ATTENDING PHYSICIAN.*

ALL ITEMS SHOULD BE BILLED AT AMOUNTS CUSTOMARILY CHARGED. HOWEVER, FEES IN EXCESS OF THOSE AUTHORIZED BY THE DIVISION OF WORKERS' COMPENSATION ARE SUBJECT TO REDUCTION. ONLY UNDER SPECIAL CIRCUMSTANCES WILL OVER-THE-COUNTER DRUGS BE PAID.

DWC-MIS PF-472 (Rev. 11/84) DS 270

APPENDIX B

PUBLICATIONS MAILING ADDRESSES

Publications may be ordered direct from the publisher or from the Division of Workers' Compensation.

Publications ordered from the Division may be ordered through the Insurance Compliance Bureau, 5 South Last Chance Gulch, Helena, Montana 59601.

Postage costs will be added to the publications ordered from the Division and all orders must be prepaid.

DIVISION OF WORKERS' COMPENSATION PRICES

Official Medical Fee Schedule (OMFS)	$7.60
Relative Value Guide (ASA)	$4.40
1985 Health Care Procedure Coding Schedule	$14.50

To make direct orders, use the following addresses:

For Relative Unit Guide:

Publication Department
American Society of Anesthesiologists
515 Busse Highway
Park Ridge, Illinois 60068

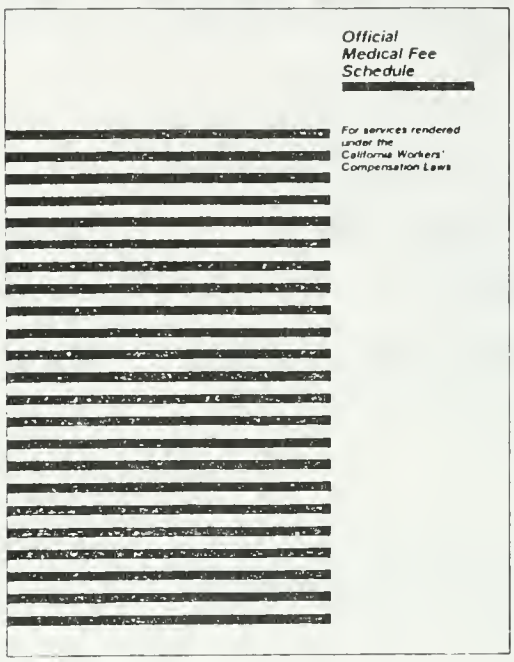
Price - $4.00 per copy prepaid

For 1985 Health Care Procedure Coding Schedule:

Superintendent of Documents
U.S. Goverment Printing Office
941 North Capitol Street
Washington, D.C. 20401

Price - $12.50 per copy prepaid

Official Medical Fee Schedule



The Official Medical Fee Schedule governs billing and payment of physicians' services provided injured employees under the California workers' compensation law.

The Schedule incorporates recent changes promulgated by the State Division of Industrial Accidents. A separate insert summarizes principal provisions of the California law affecting physicians and includes the table of conversion factors applicable to medical services furnished on or after January 1, 19~~84~~85

Cost is $7.15 per copy, prepaid, which includes sales tax and shipping charges. (For quantity orders of 25 or more copies shipped to the same address, please contact CWCI, 120 Montgomery Street, Suite 715, San Francisco, CA 94104, telephone 415/981-2107.

Order Form

Official Medical Fee Schedule

California Workers' Compensation Institute
120 Montgomery Street, Suite 715
San Francisco, CA 94104

Enclosed is my check for $_____ for _____ copies of the Official Medical Fee Schedule.

FIRM_____

ATTENTION_____

STREET_____

CITY/ZIP_____

PHONE_____

1,200 copies of this public document were published at an estimated cost of $1.00 per copy for a total estimated cost of $1,200.00, which includes $855.00 for printing and $345.00 for distribution.